Missouri Department of Mental Health
Office of Deaf Services
Interpreter Exchange Program Application

Name:	**DOB:**
Address:	**Phone Number:**
Missouri Interpreter Certification Level (circle one):	**Mater Advanced Basic CDI**

1. **What experience do you have in interpreting in the mental health field?**

2. **What training have you received in mental health interpreting?**

3. **Why do you want to participate in this program?**

4. **What do you plan to use this training for?**

Signature: _____ **Date:** _____

For DMH-ODS Use only

Approved: Yes No

Date to complete hours: _____

ODS Director Signature: _____

Financial Representative Signature: _____